



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KENNETH BERLINER
15769 NORTH FREEWAY
HOUSTON TX 77090

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-05-2914-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "No MAR for this procedure although it should be reimbursed @ 50% this proc is performed in an attempt to avert the need for the lumbar fusion surgery."

Amount in Dispute: \$19057.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This carrier reimbursed the requester for the service performed, electrothermal annuloplasty L3-4 and L4-5." "This carrier's reimbursement is based on the reimbursement (Exhibit 2) for code 62287..."

Response Submitted by: Texas Mutual Insurance Co., P.O. Box 12029, Austin, TX 78711-2029

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 27, 2004	CPT Code 22899 (X2)	\$19057.26	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. 28 Texas Administrative Code §134.202, titled *Medical Fee Guideline*, effective January 5, 2003, sets the

reimbursement guidelines for the disputed services.

5. This request for medical fee dispute resolution was received by the Division on December 17, 2004.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits dated October 8, 2004

- YG-Reimbursement for this procedure is included in the basic allowance for another procedure.
- YM-The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(D).
- M-No Mar
- G-Unbundling

Explanation of Benefits dated December 7, 2004

- O-Denial after reconsideration.
- 891-The insurance company is reducing or denying payment after reconsideration.
- 217-The value of this procedure is included in the value of another procedure performed on this date.

Findings

1. 28 Texas Administrative Code §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."
2. 28 Texas Administrative Code §134.202(c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."
3. CPT code 22899 is defined as "Unlisted procedure, spine." CPT code 22899 does not have a relative value unit assigned; therefore, reimbursement shall be provided in accordance with 28 Texas Administrative Code §134.1.
4. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
7. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
 - The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states "No MAR for this procedure although it should be reimbursed @ 50% this proc is performed in an attempt to avert the need for the lumbar fusion surgery."
 - The requestor does not discuss or explain how \$9875.00 reimbursement for code 22899 is a fair and reasonable reimbursement.
 - The requestor did not submit documentation to support that payment of the amount sought is a fair and

reasonable rate of reimbursement for the services in this dispute.

- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	3/22/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.